5992 Howdershell Road, Suite 106, Hazelwood, MO 63042
(314)731-1299 fax (314) 731-2145

PATIENT INFORMATION FORM

PATIENT'S NAME_____ SEX: MALE___ FEMALE___

ADDRESS_____ CITY_____ STATE_____ ZIP_____

PHONE # (____) _____ DATE OF BIRTH_____

MOTHER'S NAME_____ SSN_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

HOME PHONE # (____) _____ DATE OF BIRTH_____ LEGAL CUSTODY? YES__ NO__

WORK PHONE # (____) _____ EXT____ EMPLOYER_____ CELL PHONE # (___) _____

EMAIL ADDRESS_____

FATHER'S NAME_____ SSN_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

HOME PHONE # (____) _____ DATE OF BIRTH_____ LEGAL CUSTODY? YES__ NO__

WORK PHONE # (____) _____ EXT____ EMPLOYER_____ CELL PHONE # (___) _____

EMAIL ADDRESS_____

LEGAL GUARDIAN'S NAME_____ SSN_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

HOME PHONE # (____) _____ DATE OF BIRTH_____ LEGAL CUSTODY? YES__ NO__

WORK PHONE # (____) _____ EXT____ EMPLOYER_____ CELL PHONE # (___) _____

PRIMARY INSURANCE COMPANY_____ GROUP #_____

ID #_____ POLICY HOLDER_____

SECONDARY INSURANCE COMPANY_____ GROUP #_____

ID #_____ POLICY HOLDER_____

NAME OF INDIVIDUALS NOT LIVING WITH YOU WHOM YOU AUTHORIZE US TO CONTACT AND DISCUSS PROTECTED HEALTH INFORMATION IN CASE OF EMERGENCY OR INABILITY TO CONTACT YOU AT THE ABOVE LOCATIONS.

NAME_____ PHONE #_____
NAME_____ PHONE #_____
NAME_____ PHONE #_____

I HEREBY ATTEST THAT I AM LEGALLY AUTHORIZED TO MAKE DECISIONS REGARDING THE ABOVE NAMED PATIENT AND I AUTHORIZE BROWNRIDGE PEDIATRICS P.C. AND THEIR STAFF TO TREAT THE ABOVE NAMED PATIENT AND TO USE THE INFORMATION OBTAINED FOR TREATMENT OBTAINING PAYMENT AND HEALTHCARE OPERATIONS.

SIGNATURE_____ DATE_____

Brownridge PEDIATRICS
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Medical Information Form

PATIENT'S NAME_____ SEX: MALE __ FEMALE__ AGE_____
DATE OF BIRTH_____ RACE/ETHNICITY _____

Birth History

BIRTH WEIGHT_____LBS _____OZ
BIRTH HOSPITAL_____ BIRTH CITY/STATE_____
WERE THERE ANY COMPLICATIONS WITH THE PREGNANCY? YES __ NO __
IF YES, WHAT?_____
DID YOU HAVE A VAGINAL DELIVERY OR A C-SECTION? _____
IF C-SECTION WHY? _____
WERE THERE ANY COMPLICATIONS WITH THE LABOR OR DELIVERY? YES __ NO __
IF YES, WHAT WERE THE COMPLICATIONS?
_____
WERE THERE ANY PROBLEMS WITH THE BABY IN THE NURSERY? YES __ NO __
IF YES, WHAT WERE THE COMPLICATIONS?
_____
WAS YOUR CHILD JAUNDICED IN THE NEWBORN PERIOD? YES __ NO __
DID YOUR CHILD RECEIVE THE HEPATITIS B VACCINE? YES __ NO __ DATE SHOT GIVEN_____
DID YOU __ SMOKE, __ DRINK, OR __ USE DRUGS DURING THE PREGNANCY?
TYPES OF DRUGS USED _____

IS YOUR CHILD ALLERGIC TO ANYTHING INCLUDING MEDICINE? YES __ NO __
IF SO, WHAT? _____

CIRCLE THE CHILDHOOD DISEASES YOUR CHILD HAS HAD.
CHICKEN POX MEASLES MUMPS GERMAN MEASLES(RUBELLA) WHOOPING COUGH TETANUS
STREP THROAT SCARLET FEVER MENINGITIS(WHAT TYPE?) _____

ARE YOUR CHILD'S IMMUNIZATIONS UP TO DATE? YES __ NO __
(PLEASE PROVIDE A COPY OF THE SHOT RECORD)
LIST ANY FOODS YOUR CHILD CANNOT TOLERATE. _____
LIST ANY PREVIOUS HOSPITALIZATIONS. _____
LIST ANY PREVIOUS SURGERY. _____
LIST ANY ILLNESS YOUR CHILD HAS HAD. _____
LIST ANY BROKEN BONES YOUR CHILD HAS HAD. _____

CIRCLE ANY ILLNESSES THAT RUN IN THE FAMILY
ASTHMA* BIRTH DEFECTS* CANCER(TYPE?) _____ * CEREBRAL PALSY* ADD/ADHD* DIABETES*
HIGH BLOOD PRESSURE* HEART DISEASE* KIDNEY DISEASE* LUNG DISEASE* MENTAL
DISEASE(TYPE?)_____* SICKLE CELL ANEMIA OR TRAIT* GASTROINTESTINAL DISEASE*
OTHER_____

IF THE PATIENT IS A GIRL, HAS SHE STARTED HER MENSTRUAL PERIODS YET? YES __ NO __
AGE OF 1ST PERIOD _____.

LIST YOUR CHILDREN AND THEIR AGES FROM OLDEST TO YOUNGEST
NAME _____ AGE_____ SEX __ MALE __ FEMALE
NAME _____ AGE_____ SEX __ MALE __ FEMALE
NAME _____ AGE_____ SEX __ MALE __ FEMALE
NAME _____ AGE_____ SEX __ MALE __ FEMALE
NAME _____ AGE_____ SEX __ MALE __ FEMALE

HOW DID YOU FIND OUT ABOUT BROWNRIDGE PEDIATRICS? _____

SIGNATURE _____ DATE _____

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FINANCIAL POLICY

Thank you for choosing Brownridge Pediatrics as your child's health care provider. We are committed to quality management of your child's health.
Please understand that payment for your services is part of the treatment. The following is a statement of our financial policy which we require that the guardian sign prior to your child being treated.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. We accept Cash, MasterCard, Visa, American Express, Discover and approved personal checks or debit card transactions.

A. Regarding Insurance, we accept a number of HMO, PPO, and POS options. ALL CO-PAYS AND NON-COVERED SERVICES ARE DUE AT THE TIME OF YOUR OFFICE VISIT.

B. OTHER INSURANCE:

a. You may pay at the time of service for all insurance plans in which we do not participate.

b. We will provide you with a receipt of all services rendered including the account billed. This will allow you to submit a claim to your insurance company for reimbursement.

Please be aware that we are not part of your insurance policy and that the policy is a contract between you and the insurance company.

c. We will not be liable for any payment or reimbursement that the insurance company does not make.

C. MEDICAID:

We require that all Missouri Medicaid patients provide us with proper identification and insurance cards at the time of service.

D. MISSED APPOINTMENTS:

UNLESS CANCELLED AT LEAST 24 HOURS PRIOR TO YOUR APPOINTMENT, YOU WILL BE CHARGED $25.00 FOR EACH MISSED APPOINTMENTS.

E. BOUNCED CHECKS:

YOU WILL BE CHARGED $27.00 FOR A BOUNCED CHECKS. THIS FEE IS IN ADDITION TO THE FEES TO THAT MAY BE REQUIRED
BY THE CHECK CLEARING HOUSE.

_____ _____
(SIGNATURE OF RESPONSIBLE PARTY) DATE

_____ _____
(SIGNATURE OF CO-RESPONSIBLE PARTY) DATE

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ACKNOWLEDGEMENT OF RESPONSIBILITY

PATIENT NAME _____ DATE OF BIRTH _____

RELEASE: I HEARBY AUTHORIZE BROWNRIDGE PEDIATRICS P.C. TO FURNISH ANY INFORMATION REQUIRED TO PROCESS THIS CLAIM.

ASSIGNMENT: I AUTHORIZE AND REQUEST PAYMENT OF MEDICAL BENEFITS TO BROWNRIDGE PEDIATRICS P.C. AND ACKNOWLEDGE THAT
I AM RESPONSIBLE FOR ANY UNPAID BALANCE THAT MAY BECOME DUE AFTER MY INSURANCE HAS PAID ITS PERCENTAGE.

ACKNOWLEDGEMENT: I HAVE BEEN OFFERED TO RECEIVE AN ELECTRONIC OR PAPER COPY OF THIS FORM WHICH INDICATES THAT ANY
UNPAID BALANCE WHICH BECOMES DELIQUENT WILL START TO ACCRUE ANNUAL INTEREST AT A RATE OF 8 %.

_____ _____
(SIGNATURE OF RESPONSIBLE PARTY) DATE

_____ _____
(SIGNATURE OF CO-RESPONSIBLE PARTY) DATE

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for BROWNRIDGE PEDIATRICS P.C. to use and disclose protected health information (PHI) about me and/or my child to carry out treatment, payment and health care operations (TPO).

The Notice of Privacy Practices provided by BROWNRIDGE PEDIATRICS P.C. describes such uses and disclosures more completely. I have been provided the Notice of Privacy Practices prior to signing this consent. BROWNRIDGE PEDIATRICS P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Barbara Parks, 5992 Howdershell Road, Suite 106, Hazelwood, MO 63042.

With this consent, BROWNRIDGE PEDIATRICS P.C. may call my home or other alternative location to leave a message on voice mail or in person in reference to any items to assist the practice in carrying out TPO such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results, among others.

With this consent BROWNRIDGE PEDIATRICS P.C. may mail to my home or other alternative locations any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

With this consent BROWNRIDGE PEDIATRICS P.C. may e-mail to my home or other alternative locations any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements. I have the right to request that BROWNRIDGE PEDIATRICS P.C. restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restriction, but if it does it is bound by the agreement.

By signing this form, I am consenting to allow BROWNRIDGE PEDIATRICS P.C. to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, BROWNRIDGE PEDIATRICS P.C. may decline to provide treatment to me or my child.

In order to protect your right to privacy in accordance with the HIPAA privacy rules, BROWNRIDGE PEDIATRICS P.C. has established this consent form which restricts disclosure of your protected health information to unauthorized individuals. By signing this form you are telling us who you will allow us to communicate with should someone else bring your child into our office.

_____

I (we) give consent for BROWNRIDGE PEDIATRICS P.C. including all health care providers and their employees or assistance to use or disclose protected health information of my child or legal dependent solely for the purpose of treatment, obtaining payment or health care operations or health care operations. I (we) understand that I (we) have the right to review the BROWNRIDGE PEDIATRICS PRIVACY NOTICE to request restrictions and to revoke this consent in writing at any time. I certify that I (we) am (are) the legal guardian(s) or parent (s) of this child with legal custody and rights to direct his/her health care. I also authorize the persons listed below to act on my behalf in my absence and to have access to protected health information relating to my child.

_____

X_____ _____
(Signature of Patient or legal guardian) Date

_____ _____
Signature of 2nd Parent or Legal Guardian Date

Child's Name _____ Date of Birth _____

Person's authorized to bring my child to the doctor Relationship

_____ _____

_____ _____

_____ _____

_____ _____